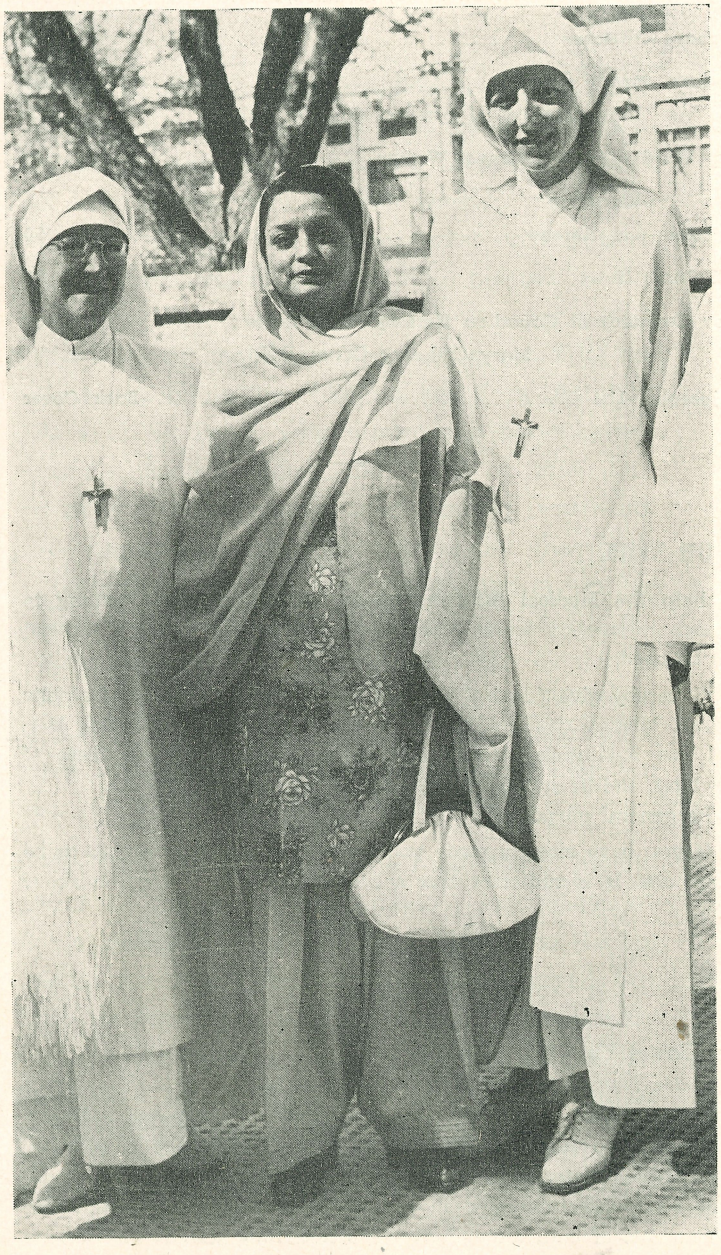
THE MEDICAL MISSIONARY



July-August 1948

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YOUR WILL

can help the Medical Mission Sisters bring health and healing to the sick in mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries Inc. (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $..... for its general purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above form.

Our Cover This Month:

Lady Liaquat Ali Khan, wife of the Prime Minister of Pakistan, paid a visit to Holy Family Hospital, Rawalpindi. She is pictured here between Sister Alma Julia, (left), and Sister M. Damian. Lady Khan was most interested in our training school for nurses. The governments of both Dominions are establishing schools for nursing since there are only 7,000 nurses in a land of 400 million people.

THE MEDICAL MISSIONARY

8400 Pine Road

Sister M. Christine, S.C.M.M., Editor

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THE MEDICAL MISSION SISTERS

Who they are:

The Medical Mission Sisters are a religious community devoted to the care of the sick in the missions. Some of the Sisters are doctors, nurses or pharmacists; others are engaged in secretarial, household and similar duties necessary for medical mission work.

Main Activities

Hospitals, dispensaries, home visiting, leprosaria, training native nurses, training native compounders, maternity and child welfare clinics, establishing native Medical Mission Sisterhoods.

To cope with the numerous requests from mission bishops for medical mission centers, many vocations are needed.

Houses of the Society

Motherhouse and Novitiate — 8400 Pine Road, Fox Chase, Philadelphia 11, Pa.
House of Studies—6th & Buchanan Sts., Washington 17, D. C.
Postulate; Osterley, Middx. England
Heerlen, Holland

Missions

PAKISTAN
Holy Family Hospital—Rawalpindi
Holy Family Hospital—Karachi

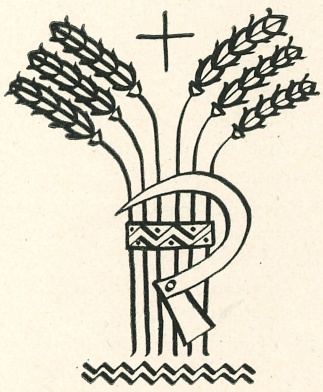
INDIA
Holy Family Hospital—Patna
Holy Family Hospital—Mandar

INDONESIA
Maternity Clinic, Stella Maris Hospital, Makassar, Celebes

AFRICA
Holy Family Dispensary — Berekum, Gold Coast

UNITED STATES
Catholic Maternity Institute
Santa Fe, New Mexico
The Catholic Colored Clinic
Atlanta, Georgia

America's Hour To Aid The Missions



"Lift up your eyes and behold that the fields are already white for the harvest." John IV-35

The Church, the Mystical Body of Christ, is an organic, living being. Each of its members is vitally concerned in its growth. Hence, mission work is, and always will be, the work of the **whole** Church. All of its members must contribute to the prayers, works and sacrifices needed for this purpose. Yet circumstances have arranged that at one time or another, one nation or group of nations has borne the chief burden. From the very time of St. Peter, who moved his headquarters from Antioch to Rome, the center of missionary activity has gradually been shifting westward. As one nation after another caught the living flame, and became Christianized, each in turn became missionary to the lands still engulfed in the darkness of error and paganism. The Church in the East, so flourishing in the days of the Apostles, has languished under the double infection of schism and Mohammedanism. India, China and Japan, though early to receive the Gospel, have yet to yield to the cross of Christ.

In the course of time, the Faith was spread to the New World. Merely to mention the names of the early missionaries in America—Jogues, Flaget, Marquette, De Smet, Serra—is sufficient proof of America's debt to the nations of Europe. The Church in America is no longer in its infancy: it has reached adulthood. It is time for her to shoulder the burden of missionary work. The Catholic countries of Europe have lost nothing of their zeal for the spread of the kingdom of God. Yet the war has left them hampered as to men and means. Now is America's hour to aid the missions.

GAITRI'S LAST CHANCE

By Sister M. Elise Wynen, S.C.M.M., M.D.

A group of Indian women half-carried half-led an exhausted young girl into Holy Family Hospital dispensary one morning She looked like a skeleton except for her huge abdomen. With diffculty we put her on the examining table, but even a careful physical examination did not tell us much more than the first glance had done. The ascites (fluid in the abdominal cavity) was so large that it obscured all details. The heart and lungs appeared normal, the feet were only slightly swollen, there was a slight fever. The exhaustion and emaciation defied all description.

It is hard to extract a complete history from most Indian patients. Gaitri possessed a shy, retiring disposition, and a voluble mother-in-law. That combination spells death to all accuracy and completeness in history taking! We gathered that the girl had been sick for about a year. Gradually the ascites had become larger and larger, the rest of the body thinner and thinner. Gaitri, unable to eat or move about, was now so weak that she could hardly sit up.

Dhais, and hakims, homeopathic and ayurvedic pill-dispensers of all kinds and descriptions had been called in. They had prescribed all sorts of nauseous remedies, all equally ineffective. Most Indian drugs are like Pinkerton's Pink Pills for Pale People. They are very good . . . for Pinkerton! The doctors grow fat and wealthy, while the patients die. Gaitri's skin was covered with scars, burnings and cuttings, from plasters and counter-irritants. Hundreds of rupees had been spent, all to no avail. Finally, after months of torture, as a desperate last resort, the patient was taken to the city doctors. That is still a common story in the Indian villages. Proper medical care is so far away that it is hardly thought of until all other means have failed.

But the city doctors weren't interested. They pronounced the case hopeless, and did not want her around to die on their hands. In their usual dramatic fashion, the mother-in-law and her satelites explained how they were on their way to the station to go back to the village, when they saw our sign, HOLY FAMILY HOSPITAL. Gaitri's guardian angel must have nudged them, for they decided to give the girl one more chance. So here they were. What were we going to do about it?

To tell the truth, we didn't exactly know. This seemed to be a case of tuberculous peritonitis, and a cure at this advanced stage was unlikely to say the least. But mission hospitals are for souls as well as bodies. We never refuse a patient, not even a hopeless one. A good Christian death is a major success to us, just as much as a recovery that might make converts later on. But we know very well that the hospital is blamed if the patient dies. Still, these people had been warned. They would be well satisfied if we could make their girl a little less uncomfortable.

So we sent Gaitri into the hospital ward. There she was subjected to the usual routine of repeated questionings and examinations, for in India one never hears the whole story the first time. After a few days it struck us that Gaitri was looking better already. She was always smiling, began to respond to jokes and stories, and had no complaints except weakness. She never seemed to be in pain, either. Doubts about the diagnosis began to appear. Ordinarily patients with tuberculous peritonitis are much more toxic and grumpy. Could it be possible that it was some other illness?

It was a serious decision to make, but after a week or so we came to the conclusion that a major operation was indicated. Gaitri deserved everything possible to make her well again. Needless to say, we did not even try to explain all the details to Gaitri and her family. They would have stared at us with open mouths if we had mentioned adhesions, and the like. We merely told them that a little "cutting and sewing," as the Indians describe operations, might help Gaitri to get well.

Contrary to the usual clamor of opposition that generally follows such an announcement, the relatives were ready for anything. The fact that the case had been pronounced hopeless by the city doctors helped the cause. So one morning Gaitri's hair was braided in two little pigtails, and she was wheeled into the operating room. Her consent had been asked, but she merely smiled and referred us to her mother-in-

law. Life and death decisions like that did not belong to her. Her childlike obedience and compliance made matters much easier.

That operation was the surprise of a lifetime! Gaitri had a huge ovarian cyst, filled with fluid, interfering with digestion and locomotion, but otherwise quite innocuous. There wasn't a sign of tuberculosis. It was a matter of a few minutes to empty the sack, cut and tie off the pedicle and close the incision. If only we could pull Gaitri through the shock of this operation, she would be cured. Towards the end of the procedure, the pulse began to skip around alarmingly, as was to be expected. A year ago this would have been a simple job, but delay had made it a dangerous one. But all went well, shock treatment pulled her out of immediate danger, and she was returned to the ward for further care. The patients around her hardly recognized the now flat Gaitri.

It was a close call for several days. Prompt treatment turned the tide until recovery took the upper hand. Fortunately no dreaded complications occurred. The whole hospital was deeply interested, not only the Indian student nurses who vied with each other for the honor of taking care of this prize patient, but also the other patients and their relatives. At critical moments, the entire ward would hush its chatter, peek around the curtains, beg to be allowed to help with the fetching and carrying of impedimenta. The entire hospital filed through the corridor of the operating rooms to see the huge "thaili" (bag) that had been taken out of Gaitri. Even passing tradesmen and people in the streets were brought in to view the wonder.

This interest and honor worried us not a little. What an uproar there would be if the patient died. But Gaitri lived through the ordeal, and once she started on the road to recovery, she never turned back. She had her own explanation for her rapid return of health. "Since you took the water out of my stomach, I have room for my food," she would say, looking with happy eyes at her big plate of rice and curry, twice a day. It was a long time since she had been able to enjoy a meal. She was a pleasure to watch, exactly the same, shy, cooperative, cheerful creature she had always been, more like a child than a grown-up woman, in her complete unconcern over her own fate. "Won't I have a lot to tell the old 'buddhis' (women)!" she would say.

Six weeks later a carefully penned Hindi letter brought us the story of how the village received her on her return. She had often told us, with great glee, how no one had expected to see her again when she left. The whole village turned out to meet her, with garlanded bullocks carts, and a big, flower-decorated carrying chair for Gaitri. She was greeted like one returned from the dead. Never had the likes of it been seen in that village before. The story of this trip to the mission hospital will live long in the memories of these simple people.

An Indian Medical Mission Sister measures a dose of medicine for Gaitri

It would be nice to give this story a happy ending by telling about a whole village coming into the Church as a result of this cure. That can and does happen in India . . . but not always. Of the ten lepers who were cured by Our Lord, only one came back to give thanks. We are only sowers of the seed. In God's own good time, the harvest will ripen.

MISSION INTENTIONS

FOR JULY—"That Social Questions in India May Be Solved in Accordance with Christian Principles"

In the structure of Indian life, social problems abound. Since the sub-continent contains such a mixture of races, cultures, and religions, from the most primitive to those highly advanced, the pattern of social customs is most complex. Yet throughout the whole, there is one dominant note—the influence of religion on every detail of life. Major and minor events of life are bound up with ritualistic practices. It is this bulwark of tradition that has withstood the gallant efforts of Catholic missionaries for the past 2,000 years. Any attempt to remedy the social problems of India must start at the root. If India is to be Christianized, everything that is pagan in origin or significance must be changed. But in this process of change, the culture and national character of India must be preserved.

Because the Indian thinks that to become a Christian means to be disloyal to his country, he clings tenaciously both to his nationality and to the pagan religion which he considers inseparable from it. Only when he realizes that the religion of Christ is not a form of Western aggression will he welcome it.

Thus, the Christian principles that must be applied to social questions in India have two modes of action.

The first is to solve the numerous social problems—poverty, disease, inequalities before law, ignorance, etc. — in accordance with Christian principles. Paganism has no real solution for these problems, unless fatalism is considered a solution.

The second is to achieve this Christianization without infringing on the rights of the Indian people to have their own nation and their own culture.

India will not be conquered for Christ until its social structure is saturated with Christian principles. This is doubly urgent in the present time when India is at the crossroads of a new era.

FOR AUGUST—"Catholic Bishops and Clergy in Japan"

By Sister M. Lucia, S.C.M.M., Ph.D.

A prime requisite for the firm establishment of the Catholic Church in any country is the development of a native clergy. Though the mission intention is for *all* Catholic Bishops and Clergy in Japan, the native clergy need special prayers. They must be adequate both in number and training to govern the community of the Japanese faithful, and to extend the boundaries of Christianity by themselves alone, without depending upon the help of foreign priests.

At first sight the picture of the native clergy of Japan is a poor one indeed: slightly more than 164 priests among a population of almost 80 millions. This is after four centuries of contact with Catholicism, for August of the following year will mark the 400th anniversary of the arrival of St. Francis Xavier at Kagoshima. Some 164 Catholic priests for Japan's millions can be compared to 300 priests for the entire United States. But a closer look at the world at large, however, shows the Japanese native clergy standing at the fore of mission countries. Both as regards quantity and quality, she calls for our highest esteem and admiration.

Possibilities for training a native clergy in Japan have been very limited indeed. At first Catholic missionary enterprise in the country enjoyed relative freedom. This period was well utilized by the missionaries. Not only did they multiply converts and catechists, but despite the limitations of personnel[1] and funds, they took steps towards the formation of a native clergy. In 1580, the first Japanese seminary was opened, with 26 sons of the nobility as candidates for the priesthood. A second seminary was opened in the following year, and the work continued undisturbed until 1587.

(1) Prior to the year 1570 there never were more than six priests in Japan at one time. Of the 26 missionaries present in 1582, many had not received Holy Orders.

In that year the first of the anti-Catholic edicts was published, forbidding the Catholic religion in Japan, and ordering all foreign missionaries to leave the country within twenty days. Although this decree did not go into effect immediately, wave upon wave of increasingly severe persecution swept over the infant Church of Japan from 1587 until the middle of the Seventeenth Century. The violence of the persecution, however, did not hinder the formation of a Japanese priesthood. On the contrary, exactly in this period the work flourished. The threat of persecution caused the fusion of the two seminaries into one, whose site had to be changed repeatedly. All was destroyed in the great persecution of 1597, but two years later the work was taken up anew. In 1601, the first three Japanese priests were ordained. By 1614, eleven more were added, and a total of 50 native priests had been ordained by the year 1640.

Then for a span of two centuries, Japan deliberately cut herself off from all contact with the Western world and Christianity, mainly through the fear of being conquered by a foreign power. Christians as well as foreigners were forbidden to enter the borders, and Japanese were ordered under pain of death not to leave the country, nor to return to it from abroad. Persecutions of the remaining Christian communities continued unabated. Although even during this period several valiant missionaries succeeded in penetrating into Japan, it is obvious that under such conditions, the building up of a native clergy was out of the question.

In the second half of the Nineteenth Century, Japan began to open her country to the West in order to master the advanced materialistic culture of Europe and America. A similar hospitality was not extended to Catholicism until Japan discovered that the renewed persecutions of native Catholics proved to be a hindrance to smooth diplomatic relations. A policy of toleration towards Christianity was adopted in 1874, and finally in 1899, freedom of religion was complete. The missionaries were not slow to take advantage of this change of policy. In 1866 the Seminary of Nagasaki was reopened. By 1873, Japan had two seminaries with 73 students. The first Japanese priests of modern times, three in number, were ordained in 1882. From that date there was a slow but steady increase. There were 31 priests in 1914, 73 in 1935, and today the total is 164.

Obviously, 164 native priests among a population of over 164 million are not sufficient to fulfill the ideal of the papal encyclicals in regard to an indigenous clergy. Japan remains mission territory. Yet we may not overlook the fact that this group of priests has come forth from a Catholic population of only 109,000. One priest per 700 Catholics is a ratio that is not attained by any other mission country. South America and Oceania, the Philippines and the Dutch East Indies fall far below this ratio. In Africa, Eritrea most closely approximates it (1:2166) and her figure is unusual for that continent. On the Asiatic landmass, Indo-China is second to Japan, (1: 1181) followed by China, India, Korea and Mongolia (1: about 1500).[2] The Catholic Church in Japan can be proud of the number of her native clergy, especially when viewed against the background of her Catholic population, and the conditions prevailing in other mission countries.

The gradual transfer of the administration of dioceses into the hands of the native clergy is the normal thing in missionary work. In 1927, a beginning was made, when the Monsignor Haysaka was consecrated at Rome by Pope Pius XI as the first native bishop of Nagasaki. It was a decree of the Japanese government issued in 1940 which hastened the normal evolution of missionary work. This decree promised to grant legal personality to those religious bodies which put the administration of dioceses, seminaries and parishes into the hands of native Japanese and were satisfactory to the government in other respects. The Congregation of Propaganda Fide searched among the small group of Japanese clergy and found among them sufficient capable and saintly candidates to take charge of the sixteen ecclesiastical divisions of Japan: 6 dioceses, 2 vicariates apostolic and 8 prefectures apostolic.

At present there are great and well grounded hopes for a rapid growth of the Catholic Church in Japan. Let us pray that native vocations to the priesthood may keep pace with conversions; that the Holy Ghost may grant to the native clergy the Wisdom and Fortitude so necessary in this period; that foreign missionaries may be one with the mind of Rome in regard to native clergy; and that God may procure for Japan that peace and religious freedom in which the Church may develop according to His design.

ADVENIAT REGNUM TUUM!

(2) the ratio for the United States is 1: to about 600 of the Catholic population.

MALABAR M

Twenty years ago a young priest of Travancore (South India) determined to do something about the vast amount of sickness and suffering among his people. He thought that the solution would be to find some native Sisters, trained in the latest methods of care of the sick in the spirit of Christ. It is easy to dream dreams of this sort. It is hard work, requiring patience and perseverance to make them come true. This young priest, Reverend Sebastian Pinakatt, kept his dream before him as he labored among his people, grieved to see the pitiful sickness that weighed them down. Then in 1937 came the first hint of a practical way to solve this problem. He heard of the Medical Mission Sisters, in the United States, who did medical work in India, even had a hospital of their own, with a training school for nurses, at Rawalpindi, in the northern part of India. He wrote to Mother Anna Dengel, telling her of the great need for medical care in the south of India, and of his dream, declaring, "I feel determined to undergo any difficulty and suffer any hardship to begin a mission hospital." But Mother Dengel had only a young struggling community (12 years old at this time) with which to answer this and the other innumerable requests for Medical Mission Sisters. The only hope she could honestly give to him was his own promise to pray for a speedy increase of vocations. But she pledged help as soon as numbers permitted. She suggested that in the meantime, the candidates take up nurses training. Thus it was that on May 20, 1940, Father Pinakatt started north to our Holy Family Hospital in Rawalpindi with the first group of candidates for the proposed native Medical Mission Sisterhood. For the young women concerned, it was a courageous undertaking. It entailed completely new surroundings, different food, a new language, and above all, a change of religious atmosphere, from the vigorous Catholicism of Malabar to the strongly Mohammedan environment of the Punjab. More than that, even the language of the Catholic liturgy was strange, for these girls belong to the Syro-Malabar rite. When they completed the 4 year course of nursing and midwifery, they would return to their native land to become the nucleus of the Medical Mission Sisters of the Immaculate Heart of Mary, Queen of the Missions.

A memorable day for the Malabar was taken at the first reception, Se is seated in the center, Father Pinak at the extreme left, while Sister Vi Kalacherry, to his left.

The young women soon proved that they were able to adjust themselves to their new surroundings, and take the responsibility of nursing care. Other groups followed them, in May 1941, in September 1942, and in March 1943. Father Pinakatt always conducted them the 1,570 miles from Malabar to the north of India. On one trip home, Father Pinakatt visited a Tuberculosis sanatorium, where he found 42 Catholics, of whom 2 were bed-ridden priests. It was 3 months since a priest visited there to administer the sacraments. "This sight spoke to me of the need of Catholic medical work, and inspired me with new enthusiasm to work more zealously for the realization of our humble project . . . There is great need of such work, not only for the preservation of the Catholic population,

MILESTONES

Medical Mission Sisters. This picture ptember 8, 1944. Bishop Kalacherry att at his left. Sister Pauline is seated ncent is standing in back of Bishop

but also to maintain the health of the missionaries," he wrote to the Medical Mission Sisters at the Motherhouse in Philadelphia.

Then in March of 1943, the first group successfully passed their nursing examinations. In November of the same year, Bishop Kalacherry blessed the cornerstone for the Motherhouse of the new community, on a lovely ten acre estate called "Mary Giri." In July of 1944 the candidates took up residence. They were joined on the 21st of that month by Sister Pauline and Sister Vincent who were to train them in the principles and ideals of the religious life. In a description of the new mission, Sister Pauline remarked, "It is truly wonderful to be in a Catholic country where there are so many churches instead of temples."

On September 8, 1944, the first reception was held. The first four novices took for their religious names those of the Faithful around the foot of the Cross, because they were dedicated to the care of the sick. Ten priests, 16 Sisters and 300 people were present. Sister Pauline said, "We tried to keep it a quiet affair, but we might just as well have tried to keep an earthquake a secret. As it is customary to ring all bells during the singing of it (the Syriac Te Deum) those in the neighborhood who were not already there promptly came when they heard the bells."

The novitiate was conducted with the usual schedule of classes, spiritual exercises and domestic duties. The country lent its own flavor to all these. The hosts for Mass had to be made entirely by hand, from the grinding of the wheat to the baking of the wafers, a five hour process for each week's supply. Cocoanuts and jackfruit, bananas and cashews had to be gathered and prepared. There were novel stories about the snakes who were scared away by the picture of St. Patrick, the process of washing out the well, the special caste of rat catchers, and the use of banana leaves for plates on picnics. Then in December of 1944, the whole novitiate had to move to an old seminary in Kottayam on account of the need of space, a chronic Medical Mission complaint. It was there that Mother Dengel had the joy of visiting the little community in the early part of 1946.

The next date of note is September 8, 1946 when the pioneer group made their first vows, and received the silver engraved hearts which distinguish them from the novices.

It was all these years of preparation that led to the crowning event on March 19, 1948 when the Hospital of the Immaculate Heart of Mary was opened at Bharananganam. On this occasion the Holy Father sent the following message:

"The Holy Father on the occasion of the inauguration of the Hospital of the Immaculate Heart of Mary cordially imparts His Paternal Apostolic Blessing to your Excellency, Father Pinakatt, the Medical Mission Sisters, assembled clergy and laity, praying that Almighty God may prosper this beneficent work for the sick."

Dreams do come true, if you dream long enough, and work hard enough to see them through.

Mandar's Muddy Water

Sister M. Laetitia, S.C.M.M., R.N.

"Wh-what's that?" asked the Sister of the bhisti (water-carrier) as he emptied a goat-skinful of pale brown liquid into her basin.

"Mem-sahib," said he, in surprise, "Yih apko dhone ke liye hai." ("That is for you to wash with.")

The two Sisters gazed at their "wash water" with mingled feelings of awe and perplexity. "Shall we be dirtier before we have washed or after?" said they. Then as the *Two* were stricken by the same thought simultaneously, they called to the bhisti who was disappearing through the door with his empty goatskin slung across his back.

"Ai, pani wallah! (O, water-one!) *What* do we drink?"

To their immense relief he said they could "borrow" drinking water from a friend's well.

The *Two* had just arrived to open their new hospital in the jungle, and it was their first experience of being without water, light, and even the moderate conveniences of an ordinary Indian city.

"What about our clothes?" groaned the Sisters. "Are there any dhobis (washermen) around?"

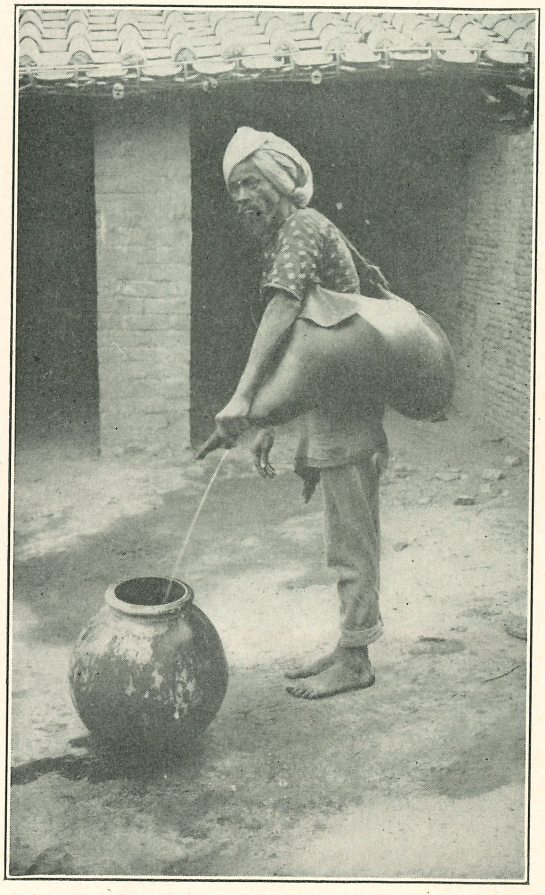
"Yes," said the cook, "I will send for him."

The "he," having turned out to be a "she," came to the hospital and departed with a big bundle of clothes on her head.

A few days later they returned via the same method of transportation. The Sisters expected to find their nice white habits a fairly deep shade of tan. Much to their surprise, they found them only a modified white; the very "mudified" areas being carefully turned inside, to be discovered later when Madam the dhobi (or dhoban, to be correct!) was far away.

Their own well had been dug, but, with the perversity of most Indian wells, it was practically empty, while their neighbor's well was full of sparkling water . . . well, if not *quite* sparkling at least the shade was decidedly less tan than theirs.

"We must make a novena," decided the *Two*. "Our plight is nearly as bad as that of the Ancient Mariner's; there may not be 'Water, water, everywhere . . . and not a drop to drink . . . ' except when the monsoon erupts, but what water there is, we cannot drink." So, "St. Joseph, send us water!" was heard floating up to Heaven.



India's water supply depends on the bhisti

After complicated negotiations with the well-digger caste, one morning a group of men with ropes and reed baskets were seen at the well, and they would alternate at digging and pulling up baskets full of black mud. Gradually the men were knee deep in water, then waist deep, and finally they were still digging with water almost up to their necks after the day's supply of water had been removed from the well.

"Inshallah! (Thanks be to God!)" sighed the *Two*, "at last, we shall have water!"

MARY WARD — A Valiant Pioneer Woman

His Eminence, the late Cardinal Bourne wrote in in 1921, referring to the development of active congregations, "I feel it a duty of gratitude to recall continually to the Catholics of England and indeed of the whole United Kingdom as well as to all the orders of religious women throughout the world that the very existence of the modern educational and charitable congregations such as we know them, was made possible by the supernatural foresight, the heroic perseverance, and sufferings of Mary Ward. She waged the battle to the point of apparent defeat, of which they are reaping the victory. To no one after their own special founders do they owe greater gratitude than to Mary Ward."

Daughter of a distinguished Yorkshire Family, she was born in 1585 and died at Heworth, near York, in 1645 after a life of suffering, opposition and . . . apparent failure. (See footnote).

"Novelty is often error for those who are unprepared for it" says Cardinal Newman, and the average mind usually is unprepared. The rules for enclosure of nuns had been reinforced by the Council of Trent. And Mary Ward founded a Congregation, the first ranking as a religious order of nuns, yet without so much of enclosure as two stakes put in form of a cross. Therewith she had the explicit design of enabling women to do for the Church what we take for granted, when we see religious engaged in parish and diocesan schools, in colleges, in any kind of social service work, in hospital and home nursing, in mission activities and in its youngest branch: medical work of women in far off countries.

Thus Mary Ward created a new ideal and a new type of the religious woman combining virginity with spiritual maternity. Like Teresa of Avila she was a revolutionary going centuries ahead of her time or rather going centuries back to apostolic times and traditions when women were the appreciated co-workers of Christ Himself and of His first disciples.

With this renewal she broke through the externals and conventions of religious life as the Middle Ages had formed it. Final triumph to apparent failure came to the Institute of the Blessed Virgin in 1703,

Mary Ward

when Pope Clement XI approved its rules but it was reserved to our century to rehabilitate her memory and throw light on her work and on her heroic virtues which, as we hope, will soon be generally recognized by the Church. Then she will take her place with St. Thomas Moore and St. John Fisher and add another glorious page to Catholic England's, and the Church's history.

"When all is done, they are but women" remarked a Jesuit one day with a shrug. These words provoked a little speech of Mary Ward to her nuns on the subject. "There is no such difference between men and women that women may not do great things as we have seen by example of many saints who have done great things. And I hope in God it will be seen that women in time to come will do much . . . "

These words of Mary Ward have become true. All possibilities and ways of study are equally open to women as to men. And they are a means to do great things for God and mankind as she set a heroic example herself. We are living in the times of opportunities for women which she foresaw. The ways now open to them to serve God and man are almost unlimited.

M. R.

FOOTNOTE: See: *Mary Ward* by Ida Coudenhove Goerres translated by Elsie Codd 1938, Longmans, New York.
"The English Way" Studies in English Sanctity, edited by Maisie Ward—Sheed and Ward 1933
Mary Ward by Maisie Ward (out of print)

At Home and Abroad

PHILADELPHIA

May brought many visitors to the Motherhouse. On the first, His Excellency, Bishop Joseph Attipetty of Verapoly, India, came, and on the fourth, His Excellency Adolph Noser, S.V.D. Bishop of the Gold Coast District of the Gold Coast (just south of the Ashanti District of which Berekum is located) gave us some first hand information of the diseases and conditions which our Sisters would meet in Africa.

On June 7, Miss Sophia del Valle, originator of the school, *Cultura Feminina,* which trains leaders in Catholic Action, spoke to us about the many phases of Catholic Action in modern Mexico.

Sister Nicholas and Sister Honorina

Sister Honorina, and Sister Nicholas, of St. Paul's Convent, Seoul, Korea, members of the Congregation of St. Paul of Chartres, spent a day at the Motherhouse. They have come from Korea to study advanced American nursing methods.

We received a copy of the first issue of "China Missionary," successor to "Collectanea Commissionis Synodalis." In an introductory letter, His Excellency, Msgr. A. Riberi, Apostolic Internuncio in China, writes: "The first issue of 'China Missionary' is appearing at a time when in a large area of China, the very existence of Christianity is under devastating attack . . . Precisely because conditions are difficult, 'China Missionary' is needed as a link uniting our embattled priestly forces." (Vol. 1, No. 1, p. 1)

ATLANTA

Catholic Colored Clinic
Atlanta, Georgia

The Octave of Easter brought garlands of spring flowers to the Clinic. The Ladies Auxiliary held their Annual Silver Tea, and the violets, jonquils and roses nodding from the new spring millinery competed well with the fresh bouquets on the tables. The women worked hard to make the tea a success, and were rewarded with a good attendance from all the parishes.

Bright and early on the morning of April 25 the telephone began its incessant ringing—each time with the same question—would we be open today? Yes, we would, but after saying this a dozen times we began to wonder just why everyone thought we would be closed. Later, we found out that it was Confederate Memorial Day.

An inevitable consequence of Spring is the window washing. One of our workers who is particularly afraid of standing on anything more than two feet off the ground, volunteered to do the windows on the outside. Standing on a three foot ladder, and trying her best not to act afraid, she was surprised by the approach of a young gentleman who offered to sell her accident insurance. She stood there and talked very seriously about the fact that she was not *in a position* to take out insurance at that time. As soon as he left, she came down off the ladder and had a good laugh.

Sister M. Philip

MANDAR

Holy Family Hospital
Mandar, India

The trip from Rawalpindi was not too exiting. I arrived in Patna Sunday morning at 3:20 a.m. It was 8:00 o'clock before it was possible for someone to come for me, but when I reached the hospital, what a welcome awaited me! Next morning, with many gifts for Mandar, I took the bus for Ranchi. The trip was lovely, even nicer than the road up to Murree. I stayed all night in Ranchi, then took the bus for Mandar, and arrived here Tuesday, the 24th, just 10 months before Christmas.

The first person I met was a Jesuit Father, who helped me carry my luggage to

our "doll house." We are really very poor, and need everything from sheets and towels and basins up to a few lockers for the patients, but most of all, help for the nurses. There are about 54 patients, and only six nurses. We really have our hands full. Two or three patients must lie on the floor until a bed is available. Last Thursday the generator was blessed by the Vicar General. Now we have light from 6 p.m. to 9:30 p.m., and from 5:30 a.m. to 6. At other times we just use our kerosene lamp.

Fortunately the ice box runs on kerosene also. Sister M. Xavier has made us some delicious ice-cream. We use only canned milk and canned vegetables, fruit and meat. Oh, it is so different from Pindi! But I must say that I love Mandar in spite of the great needs. The people are so simple and good.

Sister M. Magdalen

KARACHI

Holy Family Hospital
Karachi, Pakistan

Salaams from Karachi! We are just about settled here, so it is a good time to write. The building itself is very attractive, the floors red and white flowered tile, especially so. However, there was much repair work to be done.

It is most amazing to see all the dust in Karachi. A dry, hot wind blows it in from the nearby Sind desert. Like the rest of India, there are no screens here, consequently, "Flit" cans are much in evidence. The greatest luxury for these poor people is the possession of a mosquito net.

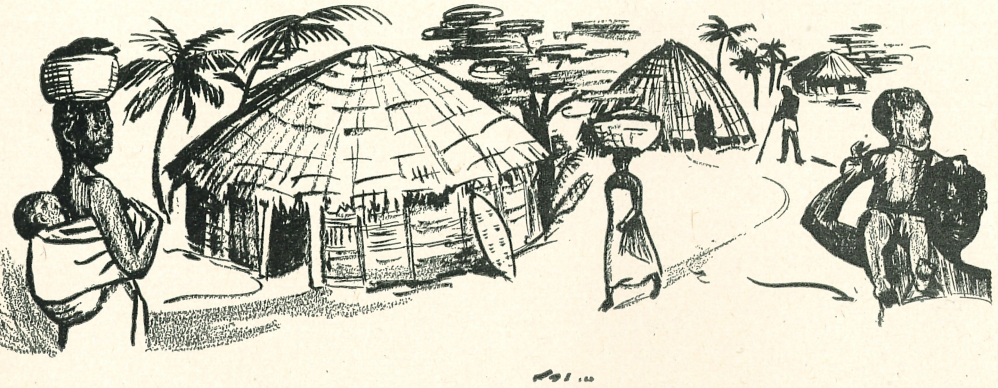
Since most of our patients are Goans, the language problem is much easier. I really like Urdu, and am anxious to be able to use it properly. Our Sisters in Pindi used so many Urdu words in their English conversations that I was able to pick up a quite a vocabulary just from listening. It sounds so funny to hear the Indians saying "O.K.," and the Americans, "ACHCHA" (all right).

There is much to be done here. Already a number of patients critically ill with typhoid have been admitted. It takes a lot of nursing care to cure them.

The religious fervor of the Moslems is a continuous source of amazement to me. We see the women with their rosary beads and their lips moving in prayer. We had an Afghan patient here for two weeks. He was able to be up most of the time, and used to take his prayer mat out on the front verandah or in the garden, five times a day, to say his prayers. Almost every time a nurse went into his room he was reading the Koran.

Sister M. Regina

A "Ladies' Compartment" in a Pakistan train would not be complete without a Mohammedan woman in her burkha. The two Sisters in this compartment are Sister M. Regina and Sister M. Dolores, on their way from Rawalpindi to the new mission in Karachi.



GOLD COAST NEWS

We observed in the African Hospital at Kumasi for fourteen days. The nursing supervisor in charge had the two weeks mapped out, and after that schedule we could stay in any department we wished. The first two days were spent in visiting all the wards, the senior nurse of each ward giving a brief history of the patients. There are many cases of pneumonia (or severe chest pains) from residual malaria, tropical ulcer, several cases of sleeping sickness, yaws, amebic dysentery, tuberculosis, worms of all kinds, and typhoid. The sleeping sickness cases are especially pathetic because generally they are in the last stages with damage to the central nervous system resulting in varying degrees of insanity. We were told that native medicine is generally resorted to, and the patients are brought to the hospital only when too far gone for help. One young boy from an ordinary home and usual native diet had a severe case of malnutrition. Although he looked like a child of 8 or 9 years, he is 17 years old.

Then we observed for two days in the eye clinic. Almost every patient had a different condition, many looking like the classic text book examples. Dr. Hoopenhauer, the eye doctor, was born in the Gold Coast 64 years ago of missionary parents. He received his M. D. in Germany, and lectured there for a few years. Aside from that he has lived all his life in the colony. They say he knows more about the native customs and medicines than anyone in the Gold Coast.

One day, Dr. Williams took us to a Sleeping Sickness Clinic in one of the villages near Kumasi. This is one of many such centers set up by the Trypanosomiasis Campaign to control the disease which is so widespread in this area. This Abrepo center which we visited is near the Kumasi waterworks. The surrounding lake and swamp land is a perfect breeding place for the tsetse fly, and the incidence of disease is high in this section. Some 80 to 100 patients are treated here weekly. As this center services villages which are 30-40 miles away, it can be gathered how important a factor is this campaign work. Prognosis is quite favorable if the patient is treated soon enough. The people are conscious of the danger and come to the clinic when they feel feverish and sick. We have seen several patients in the final stages in which sleep and coma have set in. The one difficulty is that as soon as the symptoms clear up after a few injections, the native neglect to complete the treatment.

We also visited the waterworks of Kumasi. A large plant gives the water a complete process of filtration and chemical purification—it is purer than the water of London. Some 700,000 gallons are pumped daily from this station. Plans for a waterworks system are under way at Berekum, and the chief promises that work will soon be started, and the project completed, at least in ten years. This would mean a source of electrical power for the village also.

From our observation at the hospital we concluded that one definitely must speak the native language, Twi, to be understood. The English spoken is pigeon English, and it is not as common as we anticipated. We expect soon that we shall do all our twittering in *Twi*. Africa is much bigger than we thought. There is so much room for medical work.

You can't help loving the people here. They are so cheerful and have a grand sense of humor. They are so picturesque in their native dress. If only they do not become Europeanized. We have already shelved the word "rush." It is out of tune here.

Sister Raphael and Sister Paula

THREE CENTURIES OF CANADIAN NURSING

By John Murray Gibbon and Mary S. Mathewson, R.N., B.S.

MacMillan Co. of Canada Ltd., Toronto 1947 — 500 pp.

This is a history of nursing and not just of hospitals, of women who recognized a need when it arose and met it to the best of their ability, with devotion and the medical science of the day. From the foundation of the famous Hôtel Dieu of Quebec in the Seventeenth Century by the Duchess d'Aiguillon, through the era of fever sheds along the shores of the St. Lawrence during the epidemics of the Nineteenth Century immigration, to the establishments of the modern scientific institutions, the influence of the nurse in Canada is traced. Sister and lay nurse receive due recognition as the vocation and profession developed from one of self-teaching to one of highly skilled technique. Written always in relation to the social and economic history of the country, the interesting story is drawn as much as possible from personal descriptions of eye-witnesses. These dispatches throw a warm and humanizing light on the simple facts of the record. The result is an account fascinating in its detail and inspiring in its testimony to the steadfastness and courage of those who practiced their profession in what were often dangerous times. If there appears to be repetition in the record of conditions, evils and necessary remedies, it is the repetition of history itself as the people pioneered and progressed and the country grew.

The instructors in Schools of Nursing in Canada have often felt the lack of accurate material on the history of Canadian Nursing. In her career as Assistant Director of the School for Graduate Nurses, McGill University, and as Director of Nursing, The Montreal General Hospital, Mary S. Mathewson was often convinced of the need of such a textbook. John M. Gibbon, Canadian historian, is her collaborator on the first detailed and reliable history of nursing in Canada. The range is wide. Nursing in the nine provinces is thoroughly explored with particular emphasis on Nursing Education, Public Health and Psychiatric Nursing from 1914 to the present day.

Those interested in nursing, medicine or the mores of a people will read these five hundred pages with profit. The medical missionary will find justification in his or her work. Time and again the priest in the Canadian home missions found his work hindered and often destroyed by sickness and needless deaths. Skilled medical attention for himself and for his people was essential for the firm establishment of a living Church. The Sisterhoods generously spent themselves to build and maintain efficient hospitals, and the work prospered. Necessary as such institutions are in medically developed Canada, they are indispensable in the medically undeveloped mission areas. Confirmation of the role medical missions play in the establishing of the Church in a new country is found in these pages.

Mary Catherine Cutler, R. N.

R. I. P.

Please pray for the repose of the souls of:

Rt. Rev. Msgr. Edward L. Buckey
Washington, D. C.
Mother Mary Angela Crawford
Pittsburgh, Pa.
Mr. R. Pieri
Atco, N. J.
Prof. J. C. Sperrin Johnson
Black Rock Castle
Cork, Ireland
Mr. O. M. Lorenz
Dubuque, Iowa
(Father of Sister Sarah)
Mrs. Cordelia Le Duc
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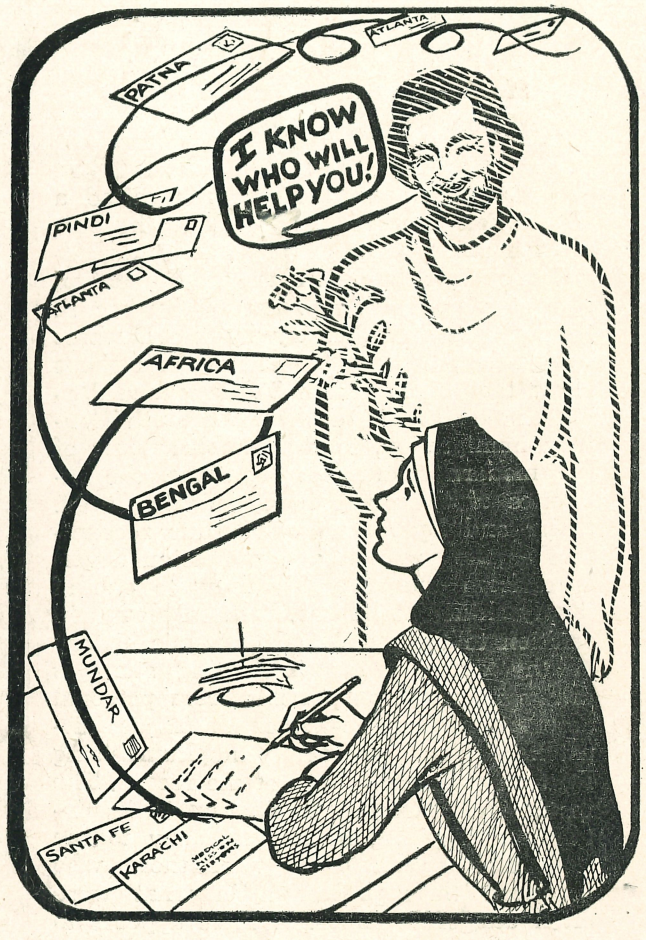

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Sincerely,

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